M'Naghten Revisited - Back to the Future? (The Mental Illness Defence - A Psychiatric Perspective)

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Introduction

The defence of mental illness in Australian jurisdictions (and in many other jurisdictions throughout the world) is defined by either the M'Naghten Rules[1] or some variant of them. According to these Rules,

> To establish a defence on the ground of insanity it must be clearly proved that, at the time of committing the act, the party accused was labouring under such a defect of reason from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know that what he was doing was wrong (Fisse 1990:448).

In summary, there are three basic elements in the Rules. The first is a statement of the type of mental state ('defect of reason from disease of the mind') that must have been present at the time the crime was committed for the defence to be a possibility. The second and third elements are statements about the consequences that must flow from this state of mind to qualify the person for the defence.

All the terms and phrases in the Rules are riddled with conceptual and definitional problems that have posed difficulties for the law and psychiatry alike for over one hundred and fifty years. In the main, the courts have attempted to deal with these problems by interpretations which have varied widely from one jurisdiction to another and have sometimes been so wide as to constitute a virtual re-writing of the law.

Psychiatry has attempted to deal with the problems by stretching its terminology and concepts to extreme and sometimes contorted limits, caricatured by Milte et al (1975:162) as 'much semantic juggling in an endeavour to fit a square psychological peg into an essentially round criminal law hole'. These contortions on the part of both the courts and psychiatry, combined with the problems inherent in the adversarial system (Shea 1996:91), have led to the defence of mental illness having a somewhat uncertain and variable application and outcome.

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1 Often referred to by the alternative spelling 'McNaughton Rules'. Hereinafter referred to as the 'Rules'.

In Australia, many attempts have been made to change the Rules. Indeed, with the exception of New South Wales, each State government, the ACT and, more recently, the Commonwealth Government through its Criminal Code Act, 1995, has put a great deal of effort into reviewing and revising the M'Naghten Rules, replacing the common law rules with a statutory statement of the law, in either a criminal code (as in Queensland, Western Australia, the Northern Territory and Tasmania) or other statutory legislation (as in South Australia, Victoria and the ACT). The result is that there are now eight forms of what were originally the M'Naghten Rules in operation throughout Australia - the original, in New South Wales, and seven variants.

Unfortunately, the revisions have all begun with the premise that the three elements of the original Rules should remain, albeit reworked or reworded. The first element is the one with the most variations. The main change in all the variants is the removal of the phrase 'defect of reason'. This eliminates the problematic and limiting cognitive element. The phrase 'disease of mind' is then either reworded as 'mental disease' (Tasmania) or replaced with a number of alternatives, such as 'mental impairment' (Victoria), 'mental dysfunction' (ACT) and even 'abnormality of mind' (Northern Territory), all aimed at widening the range of mental illnesses that can come within the ambit of the defence; and all bringing with them their own definitional problems (Shea 1999:12-13). The second and third elements have only undergone minimal changes in any of the variants, the principal change being an alteration of the words relating to 'not knowing' to words relating to a 'lack of capacity to know or understand'. For all practical purposes, the second and third elements are much the same in all the variants as in the original Rules. In some jurisdictions (Queensland, the Northern Territory, South Australia, Tasmania and Western Australia), a fourth element has been added, a volitional element dealing with the incapacity to control one's actions or conduct. This was not present in the original M'Naghten Rules. The inappropriateness of adding this fourth element to the defence is discussed below under 'Irresistible Impulse'.

This article proposes that no defence based on the three elements of the M'Naghten Rules, (and this includes all the variants in use in Australia), has any relevance to modern-day psychiatry. It will be argued that, from the point of view of contemporary psychiatric knowledge and practice, the only thing that would make sense and that would give legitimacy to psychiatric evidence in court would be to adopt a mental illness defence based on a variation of the American 'product rule'. Indeed, the seeds of this concept can be found in proposals put forward by M'Naghten's own counsel, Alexander Cockburn, at the time of M'Naghten's trial in 1843. These proposals, in turn, were based on propositions advanced by Thomas Erskine, forty-three years earlier, at the trial of Hadfield.

Before M'Naghten

The defence of mental illness has, in one form or another, been part of Western law for centuries. The seeds of the law can be found in Roman law of the third century and the Code of Justinian in the sixth (Prosono 1994:15). In England, it was firmly in place by the thirteenth century, with the development of the 'wild beast' test by Henry de Bracton, a test that, regardless of its name, 'was not in any way intended to compare the insane with wild beasts but was making the point that the insane, like animals, were not capable of forming the requisite intent to commit crime, much as a child would be incapable of forming such intent' (Prosono 1994:16).

Bracton and, later, Coke (in the sixteenth century) made it very clear that a guilty verdict required a guilty intent as well as the guilty deed, *mens rea* as well as *actus reus,* and this became the fundamental principle underlying the insanity defence.

Matthew Hale, (later Lord Chief Justice of England), writing in the seventeenth century, noted that there were four forms of insanity recognised by the law - 'ideocy' (in modern terms, severe or profound mental retardation or developmental disability of the mind), 'melancholy' (depression), 'total alienation of the mind' or 'perfect madness' (either chronic unremitting psychosis, most probably schizophrenia or mania, or dementia), and 'phrenesis' (intermittent bouts of insanity, which would probably correspond today to recurring, episodic psychiatric illnesses such as bipolar (manic-depressive) disorder or even episodic bouts of schizophrenia). According to Hale, however, only 'ideocy' and 'total alienation of the mind' could be used as a defence at law, even though Hale himself recognised that it was 'very difficult to define the indivisible line which divides perfect and partial insanity' (Ormrod 1977:4). Hard as it might have been to make this distinction, 'ideocy' and 'total alienation of the mind' continued to be the psychiatric yardsticks for the insanity defence throughout the eighteenth and early nineteenth centuries. In addition to having one of the two forms of insanity recognised by the law as qualifying a person for an insanity defence, to succeed with the defence the accused also had either (a) to not know the nature and quality of the act being performed, or (b) to not know that what he was doing was wrong (Forshaw & Rollin 1990:82; Ormrod 1977:5). Since the first criterion was too difficult to demonstrate in all but the most extreme and rarest of cases, the second (the 'right-wrong test') became the major test. It was not until the trial of Hadfield in 1800 and M'Naghten in 1843 that the situation started to change. The outcome in both cases, however, was quite different from what the leading counsels were trying to achieve for their clients.

Hadfield

Hadfield was a former army sergeant with a distinguished career. He sustained severe head injuries while on active service in Flanders in 1794 as a member of the Duke of York's bodyguard. He returned to England where he developed a series of delusional beliefs about the end of the world. He believed, inter alia, that he had to die to save the world but his beliefs did not allow him to commit suicide. He decided to kill the king, reasoning that he would be caught and executed, thereby achieving his purpose. He greatly admired the king and he did not want to kill him but could see no other way out of his dilemma. He fired a pistol at George III as he was entering his box at Drury Lane Theatre. He missed him by about twelve inches (Forshaw & Rollin 1990:83).

At his trial, Hadfield's leading counsel was Thomas Erskine, subsequently Lord Chancellor of England and, according to Ormrod (1977:5), 'one of the most brilliant advocates the Bar has ever produced'. Erskine set out to change the law in three major ways. The essence of Erskine's argument is encapsulated in the following brief extract from his erudite defence. He said:

> I must convince you, not only that the unhappy prisoner was a lunatic, within my own definition of lunacy, but that the act in question was the immediate, unqualified offspring of the disease (The State Trials Report 1977:36).

The first change that Erskine wanted to introduce was a change to the existing concept of insanity. He wanted the concept of 'partial insanity', i.e. delusions alone, 'where there is no frenzy or raving madness' (The State Trials Report 1977:36), to replace the concept of perfect insanity, because his client only had delusions and was certainly not suffering from

'total alienation of the mind'. This is what Erskine meant by the phrase 'my own definition of lunacy'. Secondly he wanted to persuade the court to bypass the previously accepted criteria of not knowing what one was doing or of not being able to distinguish right from wrong. The inability to distinguish right from wrong does not always apply in the case of delusional people and certainly did not apply in the case of Hadfield who knew that it was both legally wrong and, under less compelling circumstances, morally wrong to kill the king.

Thirdly, and most importantly, he was trying to introduce a concept which, psychiatrically speaking, is the only sensible criterion for establishing a mental illness defence, namely that, in order for the defence to be successful, there should be a demonstrable connection between the illness and the act. Erskine's argument was so powerful that the Lord Chief Justice stopped the trial and directed the jury to find Hadfield 'Not guilty: he being under the influence of Insanity at the time the act was committed' (Forshaw & Rollin 1990:83).

M'Naghten

The next major case in which the traditional defence of mental illness was challenged was that of Daniel M'Naghten, a Glasgow woodturner. On Friday, 20 January, 1843, M'Naghten shot Edward Drummond in the back. Drummond died five days later in hospital. M'Naghten had intended to kill Sir Robert Peel, the Tory Prime Minister, but somehow mistook Drummond, who was Peel's private secretary, for Peel himself. M'Naghten had suffered from delusions for several years. He believed that there was a conspiracy against him and that he was being followed and spied on by Catholic priests and Jesuits wherever he went. He believed that the police, the Tories ('on account of a vote (he) gave at a former election') (The State Trials Report 1977:49) and, indeed, 'all the world' were also involved in the conspiracy.

At his trial, his leading counsel, Alexander Cockburn, who later became Solicitor-General, Attorney-General and, subsequently, Lord Chief Justice of England, presented very much the same argument as Erskine presented in Hadfield's case and he cited Erskine extensively in his opening speech for the defence. He made it very clear, as Erskine had, that he wanted to change the law substantially. Early in his opening speech for the defence he said:

> I think it will be quite impossible for any person, who brings a sound judgment to bear upon this judgment, when viewed with the aid of the light which science has thrown upon it, to come to the opinion that the ancient maxims, which, in times gone by, have been laid down for our guidance, can be taken still to obtain in the full force of the terms in which they were laid down (The State Trials Report 1977:34).

In the opening speech for the Crown, which preceded Cockburn's address, the Solicitor-General (Sir William Webb Follett) had argued the traditional case for perfect insanity, citing Hale and several cases in which the need to retain the concept of perfect insanity had been successfully argued. Cockburn used words that were very similar to those of Erskine. He said:

> The question is not here, as my learned friend would have you think, whether this individual knew that he was killing another when he raised his hand to destroy him, although he might be under a delusion, but whether under that delusion of mind he did an act which he would have done under any other circumstances, save under the impulse of the delusion which he could not control, and out of which delusion alone the act itself arose (The State Trials Report 1977:43).

Cockburn also argued very strongly, as Erskine did, that partial insanity, i.e. delusions alone, should constitute a sufficient criterion for the insanity part of the insanity defence. By this time there was considerable support for this view from psychiatrists on both sides of the Atlantic, including Isaac Ray[2] in America and James Prichard[3] in England. Ray, in 1836, and Prichard, in 1842, the year before M'Naghten's trial, had both been highly critical of the concept of 'perfect insanity' and its stranglehold on the insanity defence. Ray, commenting on Hale, had pointed out that, in Hale's time, notions of insanity 'were derived from the observations of those wretched inmates of the mad-houses whom chains and stripes, cold and filth, had reduced to the stupidity of the idiot, or exasperated to the fury of a demon'. He suggested that 'Could Lord Hale have contemplated the scenes produced by the lunatic asylums of our times, we should undoubtedly have received from him a very different doctrine' (The State Trials Report 1977:36). Ray also supported the idea that the insanity defence should turn solely on the question of whether or not 'the mental unsoundness ... embraced the act within the sphere of its influence' and not on 'intellectual tests of the kind applied by English judges' (Ray, cited in Walker 1977:129). Cockburn cited both Ray and Prichard in his opening speech for the defence. At the end of the trial, after the medical evidence had been presented, the Chief Justice presiding over the case, Sir Nicholas Tindal, with the concurrence of the other two judges, stopped the case. He did so because all the medical witnesses who examined M'Naghten (and there were several) agreed that M'Naghten was labouring under the influence of insane delusions when he committed the crime. There was no medical evidence to the contrary. The Solicitor-General in his final address to the jury stated:

> The Lord Chief Justice has intimated to me the very strong opinion entertained by himself and the other learned judges ... that this unfortunate man at the time he committed the act was labouring under insanity ... I cannot press for a verdict against the prisoner (The State Trials Report 1977:72).

The Lord Chief Justice confirmed this in his final address to the jury. It appears that the Lord Chief Justice and his fellow judges had accepted the notion that partial insanity (in the form of delusions) should replace perfect insanity as the mental illness standard for the defence. However, the Lord Chief Justice included in his address to the jury a statement of the traditional 'knowledge of wrong' arm of the defence and made it clear to the jury that this should be the focus of their deliberations:

> If he (M'Naghten) was not sensible at the time he committed that act, that it was a violation of the law of God or of man, undoubtedly he was not responsible for that act, or liable to any punishment whatever flowing from that act ... but if on balancing the evidence in your minds you think the prisoner capable of distinguishing between right and wrong, then he was a responsible agent and liable to all the penalties the law imposes (The State Trials Report 1977:72).

The jury found M'Naghten not guilty on the ground of insanity.

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2 Isaac Ray (1807-1881) was medical superintendent of the State Hospital for the Insane, Augusta, Maine (1841-5) and, later, medical superintendent of the Butler Hospital, Providence, Rhode Island (1846-67). He was a founder member (and later President) of the Association of Medical Superintendents of American Institutions for the Insane. He wrote extensively on the subject of insanity and the law. His best known work was *A treatise on the medical jurisprudence of insanity*. According to Hunter & MacAlpine (1963, 974) the 500 page work 'was reprinted at London and Edinburgh the year after it came out, reached a fifth edition in 1871 and exerted considerable influence on American courts and laws'.

3 James Cowles Prichard (1786-1848) was the first practising psychiatrist to be appointed a Commissioner in Lunacy. He was also an ethnologist of repute. Among his publications was his treatise *On the different forms of insanity, in relation to jurisprudence, designed for the use of persons concerned in legal questions regarding unsoundness of mind* which dealt, inter alia, with the concepts of diminished responsibility and irresistible impulse (Hunter & MacAlpine 1963, 837).

After M'Naghten

M'Naghten's verdict caused a public uproar, accompanied by indignant letters to *The Times*. Queen Victoria even wrote to Sir Robert Peel to complain about it. There was also an immediate and angry debate on the subject in the House of Lords and, to defuse the issue, an 'obsolete piece of constitutional machinery' (Ormrod 1977:10) was resurrected to enable five questions to be put to the judges in the House of Lords. The questions were intended to clarify 'the law respecting crimes committed by persons afflicted with insane delusions' (cited in West & Walk 1977:74) and to resolve some associated procedural matters. Although the questions were framed in a hypothetical manner, and as the piece of constitutional machinery that had been invoked only allowed the judges to assist the House 'by giving their opinions on *abstract* questions of existing law' (cited in West & Walk 1977:75), it was obvious that they related directly to M'Naghten's case (questions one to four being framed deliberately to clarify the law relating to delusions rather than insanity in general and question five relating to a procedural matter that arose in M'Naghten's case). It was the judges' answer to the second question that subsequently came to be identified as the classical expression of the defence of insanity in English law. The question was as follows:

> What are the proper questions to be submitted to the jury when a person, alleged to be afflicted with insane delusion respecting one or more particular subjects or persons, is charged with the commission of a crime (murder, for example), and insanity is set up as a defence (cited in West & Walk 1977:74).

The now familiar answer (cited earlier) was:

> To establish a defence on the ground of insanity it must be clearly proved that, at the time of committing the act, the party accused was labouring under such a defect of reason from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know that what he was doing was wrong (Fisse 1990:448).

The second part of the judges' answer to the question, ('as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know that what he was doing was wrong'), was simply a restatement of the existing law. It was only the first part of the judges' answer ('the party accused was labouring under ... a defect of reason from disease of the mind') that constituted a change to the law, with the phrase 'defect of reason from disease of the mind', i.e. the concept of 'partial insanity', coming to replace the concept of 'total alienation of the mind' or 'perfect insanity'. While the new phrase could be seen as a forward step in the law, as it existed at the time of the M'Naghten case, it had the unfortunate restricting effect, which could not have been foreseen at the time it was introduced, of making the yardstick for insanity a purely cognitive measure. The latter, of course, has been the subject of much comment, but what many commentators have missed is the significance of a point made by Stephen J in 1883 (cited in Walker 1977:131). The judges were only asked to comment on the law as it related to 'insane delusions' and this is precisely what they did. The phrase 'a defect of reason from disease of the mind' was simply a legal expression of the medical concept of 'insane delusions'. It is important to look at the questions as well as the answers. The answer could equally have been the following, because this is precisely what it meant:

> To establish a defence on the grounds of insanity (in the case of a person alleged to be afflicted with insane delusions) it must be clearly proved that, at the time of committing the act, the party accused was labouring under such a defect of reason from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know that what he was doing was wrong.

The judges were not asked to comment on the law relating to other types of insanity. As Walker points out in his discussion of Stephen J's comments, the judges 'had not dealt (for they had not been asked to deal) with cases in which the emotions and the will are affected' (Walker 1977:131). Yet what the judges said in relation to 'insane delusions' became accepted, over time, as the defining statement for all forms of insanity. The result was that, in those jurisdictions in which the M'Naghten Rules operated in their original form, psychiatrists presenting forensic reports for offenders suffering from psychiatric illnesses with symptoms other than delusions (such as hallucinations, mood disturbances and intellectual impairment), were forced to 'massage' psychiatric symptoms unrelated to delusions and, indeed, force whole psychiatric syndromes into language that was designed for delusions alone. Some courts, in turn, accommodated psychiatrists by interpreting the M'Naghten Rules with 'increasing elasticity' (Walker 1977:135). As Dixon J noted in 1957, it had become a 'discreditable chapter of the law' (cited in Waller 1977:185). Dixon J also noted that it was most unlikely that Tindal J , when he wrote his advice to the House of Lords from which the Rules arose, would have expected his words 'to be weighed like diamonds' (Waller 1977:184) as they have been.

In spite of the dominance of the M'Naghten Rules in either an unchanged form or a modified (and sometimes merely a reworded) form in many jurisdictions throughout the Western world, the principles put forward by Erskine & Cockburn (and Ray & Prichard) continued to have an influence on jurisprudential thought right through until 1972. Since then their influence appears to have waned. It is time that these principles were brought back into the forefront of the ongoing debate about the mental illness defence.

The 'Right-Wrong' Test

The deficiencies of the 'right-wrong' test were obvious early. Cockburn raised the issue during M'Naghten's trial. He cited eminent writers on the criminal law of Scotland as follows:

> Although a prisoner understands perfectly the distinction between right and wrong, yet if he labours, as is generally the case, under an illusion and deception in his own particular case, and is thereby incapable of applying it correctly to his own conduct, he is in that state of mental aberration which renders him not criminally answerable for his actions. For example, a mad person may be perfectly aware that murder is a crime, and will admit it, if pressed on the subject; still he may conceive that the homicide he has committed was nowise blamable, because the deceased had engaged in a conspiracy, with others, against his own life, or was his mortal enemy, who had wounded him in his dearest interests, or was the devil incarnate, whom it was the duty of every good Christian to meet with weapons of carnal warfare (The State Trial Reports 1977:41).

In 1864, in England, the Association of Medical Officers of Asylums for the Insane submitted a resolution to the Royal Commission on Capital Punishment, 'condemning the right-wrong test on the grounds that "the power of distinguishing between right and wrong exists frequently among those who are undoubtedly insane"' (Walker 1977:131). The only way the courts have been able to deal with this problem (and this has only occurred in some jurisdictions) is by interpreting the 'right-wrong' test in very liberal ways.

Stephen J, for example, as a Queens' Board Judge in 1881, presided over the case of William Davis. Davis was 'a thirty-eight year old labourer who had attempted to murder his sister-in-law because ... the man in the moon told (him) to do it'. He said, 'I will have to commit murder, as I must be hanged' (cited in Walker 1977:132).

Stephen J, in his direction to the jury, stated:

> Any disease which so disturbs the mind that you cannot think calmly and rationally of all the different reasons to which we refer in considering the rightness and wrongness of an action ... may fairly be said to prevent a man from knowing that what he did was wrong (Stephen J, cited in Walker 1977:132).

In 1952, however, the English Court of Criminal Appeal made it clear that 'wrong', in English courts, meant 'contrary to the law' (Fisse 1990:457) which restricts the use of the defence but immediately re-introduces the problems raised by Cockburn and others. In Australia, the accepted interpretation of the 'right-wrong' test is that given by Dixon J in the case of *Porter* in 1933. In his direction to the jury he said,

> If through the disordered condition of the mind he could not reason about the matter with a moderate degree of sense and composure it may be said that he could not know that what he was doing was wrong (Dixon J, cited in Fisse 1990:457).

The difference between the English and Australian interpretations simply serves to illustrate the difficulty with the whole concept. It can be argued, in fact, that interpretations such as the one given by Dixon J go well beyond what the judges in the House of Lords intended and introduce a type of 'anomalous extra-legal standard' (cited in Fisse 1990:457) which, rather than being a simple interpretation of the 'right-wrong' test is, in effect, a new test altogether. Indeed, in *Porter's* case, there is little evidence that the defendant was even suffering from a 'defect of reason from disease of the mind' in the generally accepted sense and without Dixon J's novel interpretation of the 'right-wrong' test to accommodate this, it is not clear that Porter would have been given a verdict of not guilty on the grounds of insanity by the jury.

Attempts to Change the Rules

In 1924, following the case of *True*, the English government appointed a Committee on Insanity and Crime (the Atkin Committee) to consider whether any changes should be made in the existing law and the Medico-Psychological Association (later the Royal College of Psychiatrists), in its submission to the committee, suggested that Ray's formula ('Was the accused insane at the time? If so, has it nevertheless been proved ... that his crime was unrelated to his mental disorder?') should be incorporated into a new formulation to replace the M'Naghten Rules (Walker 1977:134). The Atkin Committee did not support it. Nothing came of it.

Between 1949 and 1953 in England, the Royal Commission on Capital Punishment looked at the problem again. As Walker (1977:135) points out:

> By this time many people – judges as well as psychiatrists – were prepared to say openly that the rules were being widely stretched by some (though by no means all) judges, and on occasion were not even mentioned at all. There seemed to be a tendency on the part of judges – and there certainly was on the part of juries – simply to ask themselves whether the accused had been shown to have been insane, and if so to decide in his favour without really giving thought to the tests in the rules.

'Although the Commission did not or, possibly, could not come up with a new formula, they did recommend that the law should be changed and made the important point that 'insanity and irresponsibility were not to be treated as co-extensive' (Walker 1977:136). The Commission also pointed out the obvious - that the M'Naghten Rules were based on obsolete and misleading concepts of insanity. None of the Commission's recommendations proved acceptable to the government.

The Product Rule

The first 'product rule' was introduced in the USA in the nineteenth century. It was the outcome of a six-year correspondence that Isaac Ray had begun with Judge Doe of the New Hampshire Supreme Court in 1866, a correspondence that resulted in the court accepting the view that insanity was a disease and that 'a diseased condition of mind is to be settled by science and not by law'. The resulting rule of law came to be known as the 'New Hampshire rule'. It was also known as the 'product rule' because the test was whether 'the act in question was the 'product' of a mental disease or defect' (Prosono 1994:21). Unfortunately, it did not have much effect beyond New Hampshire.

In 1954, Judge David Bazelon, in the case of *Durham v. United States,* in the District of Columbia, took up the changes that Erskine and Cockburn and Ray and Prichard were trying to bring into the law, and introduced a 'product rule' which was basically the same as the earlier one. It stated that 'an accused is not criminally responsible if his unlawful act was the product of mental disease or defect' (Goldstein & Marcus 1977:153). The principle behind the product rule was, and still is, psychiatrically sound. As Bazelon (1974:1319) pointed out, some years after this decision:

> The purpose of this decision was to grant the psychiatrist his 100-year-old request to be allowed to tell what he knows and, just as importantly, what he does not know about the phenomenon of human behaviour rather than face demands for conclusions resting on ethical, moral, and legal considerations beyond his expertise.

Sensible as the purpose was, it did not work out in practice. Bazelon blamed the psychiatrists:

> The purpose of the Durham decision was not fulfilled. Psychiatrists continued adamantly to cling to conclusory labels without explaining the origin, development, or manifestations of a disease in terms meaningful to a jury. The jury was confronted with a welter of confusing terms such as personality defect, sociopathy, and personality disorder. What became more and more apparent was that these terms did not rest on disciplined investigation based on facts and reasoning, as was required for the fulfilment of the Durham decision ... Psychiatrists did not acknowledge the limitations of their expertise (Bazelon 1974:1319).

There were two problems with the product rule as stated in *Durham*. Firstly, it left open the question of what a mental disease or defect actually was, leading to the problems raised above. As Goldstein & Marcus (1977:165) point out: 'Psychiatrists for the prosecution and defence often disagreed about whether disorders like psychopathy, sociopathy and narcotics addiction were 'mental diseases' (and) *Durham* had given the jury no standard by which to resolve the conflicting testimony'.

In an unsuccessful attempt to overcome this problem, the District of Columbia court, in *McDonald v. United States*, defined 'mental disease or defect' as including 'any abnormal condition which substantially affects mental or emotional processes and substantially impairs behaviour controls' (Goldstein & Marcus 1977:161). This was a very broad definition, so broad, in fact, that it could include all the personality disorders (including psychopathy), the paraphilias and drug and alcohol dependency, as well as the more traditional psychiatric disorders (schizophrenia, depression, mania, dementia, and delirium) put forward in the past for a mental illness defence.

Secondly, *Durham* did not define 'product' and 'attempts to bring that concept within the common experience of jurors led inevitably to reliance on disabilities of knowledge and well as critical elements in determining whether the defendant's illness had caused his unlawful act' (Goldstein & Marcus 1977:165). In 1972 the court abandoned the product rule

and replaced it with the full American Law Institute (ALI) test. The full ALI test is a combination of two tests - a cognitive test and a volitional test. The cognitive test, which can stand alone as a defence, states that a person is not responsible for criminal conduct, and hence has an insanity defence, if 'at the time of such conduct, as a result of mental disease or defect, he lacks substantial capacity to appreciate the criminality of his conduct' (Wettstein et al 1991:23). In essence, this is a modification of the M'Naghten Rules. The volitional test is an attempt to extend the M'Naghten Rules to deal with the psychologically and legally problematic concept of 'irresistible impulse', by adding the words 'or to conform his conduct to the requirements of the law' (Wettstein et al 1991:23).

Irresistible Impulse

As the notion of an irresistible impulse has been incorporated into the mental illness defence in five jurisdictions in Australia, it is worthwhile taking a moment to explain why it should not be included in the defence.

The possibility of including it in the mental illness defence was first raised by Cockburn in his defence as counsel for M'Naghten. He said:

> A man, though his mind may be sane upon other points, may, by the effect of mental disease, be rendered wholly incompetent to see some one or more of the relations of subsisting things around him in their true light, and though possessed of moral perception and control in general, may become the creature and the victim of some impulse so irresistibly strong as to annihilate all possibility of self dominion or resistance in the particular instance (The State Trials Report 1977:46).

In 1924, the British Medical Association proposed to the Committee on Insanity and Crime (the Atkin Committee) that irresistible impulse should be added to the M'Naghten Rules. The Atkin Committee supported this and recommended that:

> it should be recognised that a person charged criminally with an offence is irresponsible for his act when the act is committed under an impulse which the prisoner was by mental disease in substance deprived of any power to resist (Walker 1977:134).

The government, however, was unimpressed and the recommendations of the Atkin committee were ignored. The idea of attaching the concept of irresistible impulse to the M'Naghten Rules did not completely die, however, because a private member's bill was subsequently introduced (by Lord Darling). As Walker (1977:134) points out, '(This) would have enlarged the Rules by excusing those offenders who, through some mental disease, were "wholly incapable of resisting the impulse to do the act"'.

The Lord Chancellor (Lord Haldane), however, opposed the Bill on the ground that 'juries would be asked to decide on an impossible question' (Walker 1977:134). The Bill was rejected by the House of Lords.

Some years later, the British Medical Association put forward the proposition once again, this time to the Royal Commission on Capital Punishment and the Commission put it forward as an alternative to their principle recommendation. All the major recommendations of the Commission, including this one, were rejected by the government.

What is wrong with the concept of irresistible impulse? Haldane, cited above, had got to the nub of the problem. Kenny explains it in more detail:

> Since the occurrence of an irresistible impulse is generally admitted to be something that cannot be established by science, it is clearly not something on which expert testimony can speak with authority. But I would go further: The difficulty in telling the difference between

> the unresisted and irresistible impulse is not a temporary and contingent one which progresses in science may remove. The notion of irresistible impulse is an incoherent piece of nonsense (Kenny 1984:299).

Kenny, however, is only summing up what a number of commentators, including Lord Parker (who was responsible for introducing the concept into the defence of diminished responsibility in the case of *Byrne*) have pointed out, namely that it is simply not possible to determine scientifically the difference between an impulse which has not been resisted and an impulse which could not be resisted, either in a person who is clinically sane or a person who has a psychiatric illness. The defence of mental illness should revolve around the mental illness or otherwise of the accused, not the wilfulness or otherwise of the act. As Mawson (1990:219) points out, 'it is hard to see how the concept of irresistible impulse (has) survived for so long' and, indeed, how it continues to survive.

Back to the Future

As pointed out earlier, from a psychiatric point of view the principles that Erskine and Cockburn were trying to establish, and that Bazelon introduced into the law, were sound and sensible. The question is, how to incorporate these principles into the wording of a mental illness defence without getting into the mess that followed *Durham*.

The first and major problem is the wording of the phrase that defines the state of mind that a person must have been in at the time the crime was committed for the defence to be a possibility. Imprecise phrases such as 'mental disease' and 'mental defect' (and associated terms such as 'abnormality of mind', 'mental disturbance', 'mental dysfunction' and 'mental disorder') are always going to cause problems inasmuch as the courts have to interpret them. They do not have any precise psychiatric meanings. In Australia, psychiatrists, and most courts, have interpreted them to mean certain specific psychiatric syndromes and the syndromes that have proved most acceptable to the courts have been the major functional and organic psychoses - the schizophrenias, delusional disorders, certain types of depression, mania, dementia and delirium, although the last would be more appropriately employed as part of an automatism defence.

As Goldstein & Marcus (1977) point out, difficulties arise when psychiatrists attempt to extend the meaning of phrases such as 'mental disease or defect' to include other syndromes, particularly personality disorders and drug and alcohol dependency but also various psychoneurotic conditions. To a large extent, these attempts have been rejected by Australian courts even though these syndromes appear in both of the major classifications of psychiatric disorders in use throughout the world today - the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (the DSM-IV-TR) and The ICD-10 Classification of Mental and Behavioural Disorders of the World Health Organization (ICD-10).

But there are problems also with the use of those syndromes (schizophrenia etc.) that *have* proved acceptable to the courts. They are mainly definitional problems and boundary problems. The DSM-IV-TR and the ICD-10 differ in their descriptions of some of the major psychoses and the boundaries of diagnostic categories are blurred. As the DSM-IV-TR (2000, xxxi) itself points out:

> In DSM-IV, there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder. There is also no assumption that all individuals described as having the same mental disorder are alike in all important ways. The clinician using DSM-IV should therefore consider that individuals sharing a diagnosis are likely to be heterogeneous even

in regard to the defining features of the diagnosis and that boundary cases will be difficult to diagnose in any but a probabilistic fashion.

And even if two people are diagnosed as having, say, schizophrenia, they may present with quite different symptoms. One may present with florid delusions and command hallucinations. The other may present with neither but simply with an inability to care for himself and a difficulty in expressing clearly what he wants to say. Two people with depression may have varying depths of depression and the expression of their depression may vary greatly. One person may simply have difficulty in sleeping, a change in appetite, some disturbance in their bodily functions and difficulty in concentrating, while the other may be delusional and entirely pre-occupied with feelings of worthlessness, guilt, nihilism and recurrent thoughts of death. The diagnostic label by itself (i.e. schizophrenia or major depression) tells us very little about the person to whom the label has been applied. And it tells us nothing about the connection between the illness and the crime. Syndromes, in fact, provide courts with no useful information whatsoever. What the courts need to have is 'a description of specific signs and symptoms (and) a description of the subjective significance of the signs and symptoms to the individual who is experiencing them' (Shea 1996:41).

Symptoms are the most fertile ground in which to seek terms that have definitions that psychiatrists can agree on. Historically, of course, after M'Naghten, the presence of delusions, which are symptoms (as opposed to syndromes which are collections of symptoms brought together, sometimes on shaky grounds, for the purpose of classification), became the basis of the mental illness defence. As pointed out earlier, this changed later with the extension of the M'Naghten Rules to cover syndromes, a step that brought many problems for both the law and psychiatry in its wake. There are only a few symptoms, in fact, that need to be considered as far as the defence of mental illness is concerned. They are the ones that most courts have already found acceptable for the purposes of a mental illness defence - delusions, hallucinations, severe mood disturbance (depression or elevation) and severe impairment of intellect.

Any other psychiatric evidence is best reserved for purposes of mitigation at the sentencing stage. Most psychiatrists, presented with the same clinical evidence, would agree upon whether particular symptoms were present. This is not always the case, but it is more likely than not to be the case. Also, agreement is more likely on whether or not a particular symptom was present at the time of commission of an offence than on whether or not a person had a particular syndrome at that time. There are, however, symptoms about which psychiatrists may differ. This applies particularly to affective symptoms such as depression. Depression and its opposite, elation going on to hypomania and mania, are symptoms which come in varying strengths. While psychiatrists may agree upon the presence of these symptoms on the basis of what the person tells them or on the basis of what other observers at the time tell them, they are less likely to agree upon the strength of these symptoms because assessment of the strength of the symptoms (mild, moderate or severe) depends upon a part of the normal psychiatric examination that cannot be carried out in forensic psychiatric assessments - the mental state examination. This can only be done at the time the psychiatrist sees the patient, not retrospectively.

Using symptoms does not solve all the problems that come with the use of syndromes, but it comes about as close as it is possible to come to finding terms that are, at the one time, psychiatrically meaningful and legally useful.

The Relationship Between the Symptoms and the Criminal Act

The next problem is how to demonstrate that the criminal act was the result or product of the symptom or symptoms from which the person was suffering at the time they committed the crime. This is a difficult problem but one that must be addressed. As I have pointed out elsewhere,

> The simple coexistence of two sets of phenomena - criminal behaviour and mental disorder - especially for the first time, does not establish a causal relationship (Shea 1996:118).

There may be a causal relationship between the two but it cannot simply be assumed. It must be established. The need to do so is implicit in Erskine's words ('that the act in question was the immediate unqualified offspring of the disease') and in Cockburn's words ('he did an act which he would not have done under any other circumstances save under the impulse of the delusion which he could not control, and out of which delusion alone the act itself arose') and explicit in Ray's formula ('Was the accused insane at the time? If so, has it nevertheless been proved. . . that his crime was unrelated to his mental disorder?'). Unfortunately, it is a question that is rarely addressed by the courts. Indeed, as Hamilton (1990:209) notes, it has been generally accepted by English courts that such a connection does not have to be proved, which is logical as the M'Naghten Rules do not require such a connection to be proved. As Hamilton goes on to point out, however, the courts usually assume, even if they do not explicitly explore the issue, that the mere existence of a severe mental disorder at the time of the offence is sufficient for the assumption to be made that a causative connection *does* exist. This may be convenient and even humane in the case of minor crimes where the presence of the symptoms of a mental illness are being considered for the purposes of mitigation at the sentencing stage, but it should never happen with major crimes where a defence of mental illness is being considered.

So how does one determine whether or not there is a link between symptoms and behaviour? The only approach that can be used is to eliminate the presence of other factors that might have contributed to the offender's behaviour apart from the identified symptoms, such as evidence of conscious and rational decision-making, environmental factors, need, greed, anger, revenge, self-defence, provocation etc. If there are any such factors, then the defence of mental illness should not be allowed and the presence of psychiatric symptoms at the time of the crime was committed should become just one of the factors for the court to take into account for the purposes of mitigation at the sentencing stage. If no factors other than symptoms can be identified then it may be reasonable to assume that there was a causative link between the symptom or symptoms and the criminal act. It is important to note, however, that it is an assumption. It is not something that equates to scientific proof. In Hadfield's case and M'Naghten's case it would have been reasonable to make such an assumption. It would also be reasonable to make such an assumption in the case of a person who kills somebody in response to command hallucinations (i.e. imaginary voices telling him to kill) or delusions of persecution. There are, however, some lingering clinical difficulties. The fact is that most people with command hallucinations do not respond to them automatically. Many ignore them. Most people with delusions do not perform criminal acts in response to these delusions. So there is always the question of why some people respond to their symptoms and some do not. It might be that the strength or intensity of the symptoms varies from person to person. This, however, can be seen as a form of circular reasoning. ('How do we know how strong or intense the symptoms were? Because the person acted upon them. Why did the person act upon them? Because they were too strong or intense to resist'). Another hypothesis might be that some people have mental processes (conscious or unconscious) that counteract the influence of the symptoms and prevent the person responding to them. Both hypotheses are, of course, incapable of testing.

So, in summary, in each individual case, an assumption, but one based on all the available evidence, has to be made about whether or not there is a causative link between the symptom and the criminal act.

There is still the question of who should have the responsibility for making this assumption. As it is not something that is within the province of an expert witness in psychiatry, it should be left to the court. The role of the psychiatrist would thus be greatly simplified. His or her role would simply be to inform the court whether, in his or her expert opinion, the defendant was suffering from one or more of the four psychiatric symptoms discussed above at the time the crime was committed. In the case of mood disturbance and impairment of intellectual ability, it would also be necessary for evidence to be produced about their degree of severity. The rest would be up to the court.

A Suggestion for Reform - A New Defence of Mental Illness

The new defence of mental illness could be stated in terms similar to the following:

> A person has a mental illness defence if he or she was suffering from any one or more of four symptoms – delusions, hallucinations, severe disturbance of mood or severe intellectual impairment – at the time of the offence and the symptom or symptoms were directly causally related to the criminal act and were the only causal factors related to the act.

Should this be considered too narrow, it could be widened slightly by changing the phrase 'the only causal factors related to the act' to 'the only significant causal factors related to the act'. This would, of course, precipitate a great deal of legal argument about the meaning of the term 'significant' in individual cases.

Conclusion

There are arguments for abolishing the mental illness defence altogether. These are outlined in a comprehensive report of the Victorian Law Reform Commission Report (1990) and need not be repeated here. Indeed, there are some jurisdictions (e.g. Montana and Idaho in the United States) where the defence has been abolished although, as Steadman et al (1989:357) point out, in such jurisdictions the *mens rea* defence still exists and is really a limited mental illness defence in its own right. There are also arguments for introducing a guilty but mentally ill verdict. These alternatives have not been considered in this article. The modified form of the product rule outlined in this article would overcome many of the problems involved in the application of the various mental illness defences that embody the concepts and principles contained in the M'Naghten Rules and their variants. It would also bring the mental illness defence in Australia forward from the nineteenth century, where it had its roots, even in the states where it has been modified, and continues to have its impact, into a form that accords with modern psychiatric thought and practice, and is appropriate for application in the twenty-first century.

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